California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
Website - www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

CHANGE OF PERMIT

PHARMACY, HOSPITAL, CLINIC, NON-RESIDENT PHARMACY, LICENSED CORRECTIONAL FACILITY

A request for a Change of Permit must be filed within 30 days when the following occurs:

- Change of corporate officers/administrator
- Change of medical director (clinics only)
- Transfer of 10% to 49% of stock
- Change of street name or number made by the post office (not considered a change of location)
- Change of tradestyle name
- Change of corporate name (not a change of ownership)
- When the permit has been lost, destroyed or mutilated

To be considered complete, all of the required forms must be submitted. If the pharmacy is owned by a corporation, at least one corporate officer must sign. If it is owned by a partnership, each partner must sign; or if a sole ownership, owner must sign. Please allow four to six weeks for processing the application.

Change of corporate officers/administrator

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 1. Fee of $60.

[ ] 2. Copy of Request for Live Scan Service Form verifying that your fingerprints have been scanned and all applicable fees have been paid for each new officer. Please refer to fingerprint instructions on page 3.

[ ] 3. Completed Certification of Personnel (17A-11) form for each new corporate officer.

[ ] 4. Attach one of the following:

   a. Statement of Domestic Stock endorsed by the Secretary of State reflecting the corporate officer change, OR
   b. A copy of the board minutes reflecting the change of corporate officers.

[ ] 5. If Indian owned, a copy of the constitution and by-laws establishing the tribal council that will be the governing entity of the pharmacy.

Change of medical director

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 2. Fee of $60.

[ ] 3. Copy of Request for Live Scan Service Form verifying that fingerprints have been scanned and all applicable fees have been paid for the new medical director. Please refer to fingerprint instructions on page

[ ] 4. Completed Certification of Personnel (17A-11) form for the new medical director.

Transfer of 10% to 49% of stock

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 2. Fee of $60.

[ ] 3. Certification of Personnel (17A-11) form and Copy of Request for Live Scan Service Form verifying that fingerprints have been scanned and all applicable fees have been paid for each new stockholder. Please refer to fingerprint instructions on page 3.

[ ] 4. Copy of stock certificates, if issued.

Change of street name or number made by the post office

NOTE: a change of actual location requires a new application

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 2. Fee of $60.

Change of tradestyle or corporate name

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 2. Fee of $30.

[ ] 3. Attach one of the following: (1) a fictitious name statement from the county, (2) a copy of the Articles of Incorporation listing the new name, (3) a copy of the board minutes ratifying the name change.

When the permit has been lost, destroyed or mutilated

[ ] 1. Submit a completed and signed Change of Permit Request form (17A-12).

[ ] 2. Fee of $30.

The board may request additional information if necessary. If you have any questions or need assistance regarding the filing of your application, contact the board office at (916) 445-5014. Please allow sufficient time for processing.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $42 ($32 California Department of Justice (DOJ) fee and $10 DOJ expedite fee). (Live Scan processing fees are paid directly at the Live Scan site.)
You may contact the board to request fingerprint cards at (916) 445-5014.
You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

CHANGE OF PERMIT REQUEST

(Pharmacy, Hospital Pharmacy, Clinic, Licensed Correctional Facility, Exempt Hospital, Non-Resident Pharmacy)

TYPE OF CHANGE

CHECK ALL THAT APPLY

- ☐ Corporate Officer(s)
- ☐ Medical Director
- ☐ Transfer of 10%-49% of stock
- ☐ Address (not change of location)
- ☐ Tradestyle Name
- ☐ Corporation Name

Please print or type

Name of permit holder				Telephone Number ( )
Address of permit holder	Number and Street	City	State	Zip Code
Name of business		Permit number		Business phone number ( )
Address of business	Number and Street	City	State	Zip Code

A. Corporate Officers — LIST CHANGES ONLY

Under "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number. Non-profit organizations must list the names and titles of persons holding corporate positions.

Name of CEO		Licensed as	License number	For Office Use Only ☐ Certs ☐ FP ☐ FPC
Residence address	City	State	Zip Code	
Name of President		Licensed as	License number	For Office Use Only ☐ Certs ☐ FP ☐ FPC
Residence address	City	State	Zip Code	
Name of Secretary		Licensed as	License number	For Office Use Only ☐ Certs ☐ FP ☐ FPC
Residence address	City	State	Zip Code	

Continue on Reverse

FOR OFFICE USE ONLY

Articles of Inc ☐	Date application completed _____	Cashier # _____
Fict. Name Stmt ☐	Date changes made on system _____	Date _____
Minutes ☐	Staff initials _____	Amt of fee _____

Name of Treasurer		Licensed as	License number	For Office Use Only
				☐ Certs
Residence address	City	State	Zip Code	☐ FP
				☐ FPC
Name of Medical Director		Licensed as	License number	For Office Use Only
				☐ Certs
Residence address	City	State	Zip Code	☐ FP
				☐ FPC

B. Shareholders **COMPLETE ONLY IF THERE IS A STOCK TRANSFER**

List all persons who own 10% or more of stock (use additional sheet if necessary).

To whom issued	Residence address & telephone no.	Licensed as, license no. and state(s)	% of Shares	Date Issued

Please read carefully

The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the Executive Officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) all supplemental statements are true and accurate; (4) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

SIGNATURE

_____ _____ _____

Signature of Corporate Officer or Owner | Name (please print) | Date

_____ _____ _____

Signature of Corporate Officer or Owner | Name (please print) | Date

17A-12 (Rev. 3/99)

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STATE AND CONSUMER SERVICES AGENCY
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CERTIFICATION OF PERSONNEL

INSTRUCTIONS: **Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.** All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **will delay** the processing of your application.

1. Full name (last, first, middle)	
2. Residence address (street, city, state, zip code)	Residence telephone number ( )

3. Are you currently licensed as a physician, podiatrist, dentist, optometrist or veterinarian in this state or any other state? If the answer is "yes," please list each license number, license type, and the state(s) where you are licensed. ☐ Yes ☐ No

License Type	License Number	State	Expiration Date

4. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest, licensed in this state or any other state, as a physician, podiatrist, dentist, or veterinarian? If the answer is "yes," list the name of each person, their relationship to you, the license type, number and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name	Relationship	License Type	License Number	State

5. Are you currently, or have you previously been, listed as a corporate officer, partner, owner, manager, limited liability company member, administrator or medical director on a permit to sell, store or possess dangerous drugs or dangerous devices in this state or any other state? If "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include information regarding cancelled permits. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of company	Type of permit	Permit number	Position held	State	Expiration date

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Type of Violation	License Number	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received. ☐ Yes ☐ No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks? ☐ Yes ☐ No

If “yes,” attach a statement of explanation. If “no,” go directly to question 12.

11. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? ☐ Yes ☐ No
If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

12. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances? ☐ Yes ☐ No
If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to ensure that you are not engaging in the illegal use of controlled substances? **Please attach a statement of explanation.**

13. Will you work as an employee of this business? If yes, what will your responsibilities and duties be with this business? ☐ Yes ☐ No

_____

You must provide a written explanation for all affirmative answers to questions 3 - 12. Failure to do so may result in this application being deemed withdrawn as incomplete.

If you are a non-pharmacist owner, partner, corporate officer, corporate director or administrator of the business, you should be aware that:

(a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;

(b) you may not order a pharmacist to perform any act which is prohibited by law;

(c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;

(d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.

(e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;

(f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;

(g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);

(h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

All items of information requested on this form are mandatory. Failure to provide any of the requested information will result in the application being deemed withdrawn as incomplete. This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing certification of personnel form, including all supplementary statements ,and I personally completed this certification of personnel form.

I also certify that I have read and understand the rules of professional conduct and have retained a copy on file.

_____ _____

Signature Date

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://caag.state.ca.us/app/contact.pdf or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of $32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: _____

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

(N/A)
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

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Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

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Contact Name (Mandatory for all school submissions)

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City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

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Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

(N/A)
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed